Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHRISTINE L TRUITT MD
8042 WURZBACH RD SUITE 640
SAN ANTONIO TX 78229

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative
Box Number 54

MFDR Tracking Number
M4-13-2941-01

MFDR Date Received
July 1, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since a detailed history was done, a detailed examination was performed, counseling done with and extra time was spent with patient and his work manager to make sure they both understood everything clearly, we feel this claim should be paid."

Amount in Dispute: $215.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed the documentation and concluded that neither the history nor the examination was detailed as required by the code definition of 99214."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11, 2013	Professional Services	$215.00	$152.23

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.

- 225 – THE SUBMITTED DOCUMENATION DOES NOT SUPPORT THE SERVICE BEING BILLED.
- 890 – DENIED PER AMA CPT CODE DESCRIPTION FOR LEVEL OF SERVICE AND/OR NATURE OF PRESENTING PROBLEMS.

Issues

1. Did the requestor support use of the submitted code?
2. Did the requestor support submission of corrected claim?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the disputed service with reason code, 150 – PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE. 28 Texas Administrative Code §134.20(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation "Progress Note" finds the following;
    a. Detailed narrative with discussion of medication
    b. "He has full range of motion at the neck, but slightly increased tone. His blood pressure is 132/78 with a regular pulse of 76. He has clear, fluent speech".

   The division concludes the requestor did not support the use of AMA CPT Code 99214.

2. The requestor sent corrected bill adding 99354 with date of service 4-25-13. AMA CPT Code 99354 is described as follows: 99354 – "Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour". Review of the "PROGRESS NOTE" ADDENDUM, finds the following;
    a. "A total of 1 hour was spent with gentlemen and his employment manager as everything discussed has to be done through translation and to make sure he understands everything fully and to answer questions from his manager."

   The division concludes the requestor did support the use of AMA CPT Code 99354.

3. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2011, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Non-Facility Price or:

Code	MAR CALCULATION	Units	Allowable
99214	Not supported	1	$0.00
99354	(55.3 / 34.023) x 93.66	1	$152.23
		TOTAL	$152.23

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $152.23.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $152.23, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 25, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.